Medical Necessity Definition Summary for Virtual PACE

DHS expects ICOs administering the Virtual PACE program to ensure the provision of all medically necessary services, including drugs to enrollees as established on the individual care plan developed by the IDT regardless of Medicare and Medicaid benefit limitations, and conditions related to amount, duration, or scope or services as prescribed in either of these programs.

IDT identification and inclusion of services, including scope and duration on the care plan would be derived from clinical and health care best practices, with direct input from the area of clinical expertise analogous with the service benefit. Wisconsin's managed care program have expertise applying this definition to service authorization determinations using the resource allocation decision (RAD) method. The RAD method balances outcomes, enrollee preferences and service intervention options with the most cost effective method to meet the specified goal(s).

The proposed application of medical necessity more directly follows the PACE standards for determination of benefit coverage and avoids the inherit mismatch in Medicare and Medicaid national and local coverage determination criteria which may be less individualized and misaligned to the goals of directing care decisions from a person centered focus. This proposed approach does not appear to conflict with CMS financial alignment pre-established parameters that indicated CMS and states may allow for additional flexibility.

PACE Requirements

If a Medicare beneficiary or Medicaid recipient chooses to enroll in a PACE program, Medicare and Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply. The amount, duration and scope of services provided to PACE participants are participant-specific and are specified by the IDT in the plan of care. The scope of benefits under PACE includes any other item or service determined necessary by the IDT to improve and maintain the participant"s overall health status.

Under Sections 1894(a) and 1934(a) of the Act, PACE participants must receive Medicare and Medicaid benefits solely through the PACE organization. PACE organizations are required to provide enrollees with all medically necessary services, including drugs, without any limitation or condition as to the amount, duration, or scope. The PACE benefit includes all outpatient prescription drugs, as well as over-the-counter medications indicated by the participant's care plan. PACE programs cannot charge deductibles, copayments, coinsurance or other cost-sharing for medications.

Financial Alignment Standards

Federal Medicaid Requirement
Each State must ensure that all services covered under the State plan and are included in the plan contract are available and accessible to enrollees to the extent they are in FFS, and using a

medical necessity definition that is no more restrictive that that used in the State's Medicaid program. 42 CFR 438.210(a)(4)

Medicare Requirements

Medicare covers medically necessary Part A and B services, i.e., those that are necessary for the diagnosis or treatment of illness or injury or to improve the functioning of malformed body members. If there is a question about new services, CMS will issue a national coverage determination or local decisions will be articulated in Local Medical Review policies. MA plans may also offer supplemental benefits beyond those required under Medicare Parts A and B (e.g., dental care and vision benefits). Section 1862(a)(1)(A) of the Act. 42 CFR §422.101 and §422.102.

The Medicare definition of medical necessity under the Social Security Act states "no Medicare payment shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." To ensure that services being paid for by Medicare are medically necessary, National Coverage Determinations (NCDs) have been established by Centers for Medicare and Medicaid Services (CMS). Additionally, CMS directs Medicare contractors (i.e., Carriers/Fiscal Intermediaries (FI)/AB MACs) to establish Local Coverage Determination (LCD) policies. Although LCDs are required to be consistent with National Coverage Determinations, LCDs outline how contractors will review claims to determine if Medicare coverage requirements have been met.

CMS provides regular updates to coverage policies and all policies are available from the Medicare Coverage Database which allows you to search for national or local coverage determinations, review an index of coverage information and view new determinations. You can access the database at: www.cms.hhs.gov/mcd/search.asp.

Pre-Established Parameter and/or Preferred Requirement Standard

Preferred Requirement Standard: Medicare standards for acute services and prescription drugs and Medicaid standards for long term care services and supports, where there is overlap coverage will be determined by contract

Pre-Established Parameter: CMS and State may choose to allow for greater flexibility in supplemental benefits than currently permitted under either program, provided that they are in the blended rate. (SMD MOU template sec III.D.1).